U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 04 May 2004

Case No.: 2003-BLA-11

In the Matter of:

JACKIE E. SCOTT
Claimant

v.

BELLAIRE CORPORATION
Employer

and

DIRECTOR, OFFICE OF WORKERS
COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Thomas E. Johnson, Esq.
For the Claimant

John C. Artz, Esq.
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This case arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. ("Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718, 725 and 727 ("Regulations").

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of

their deaths. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

A formal hearing was held before me in Weirton, West Virginia on November 20, 2003. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the Regulations. At the hearing, Director's exhibits 1-50, Claimant's exhibits 1–4, and Employer's Exhibits 1–3 were admitted. (Tr. 5, 8–9).[1] The parties were provided the opportunity to submit post-hearing briefs. (Tr. 22). The Claimant submitted a post-hearing brief on February 23, 2004, while the Employer submitted a post-hearing brief on February 20, 2004.

The findings of fact and conclusions of law that follow are based upon my thorough analysis and review of the entire record, arguments of the parties, and applicable statutes, regulations, and case law. Each exhibit entered in evidence, although possibly not mentioned in this Decision, has been carefully reviewed and considered in light of its relevance to the resolution of a contested issue. The resolution of black lung benefit claims frequently requires the evaluation and comparison of conflicting evidence. Where evidence may appear to conflict with the conclusions in this case, the appraisal of the relative merits and evidentiary weight of all such evidence was conducted strictly in accordance with the quality standards and review procedures set forth in the Act, Regulations, and applicable case law.

ISSUES

The issues in this case are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the Regulations;
2. Whether the Claimant's pneumoconiosis arose out of coal mine employment;
3. Whether the Claimant's disability is due to pneumoconiosis; and
4. Whether the evidence establishes a change in conditions and/or that a mistake was made in made in the determination of any fact in the prior denial per 20 C.F.R. § 725.310.

(DX 50, Tr. 10–12.)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

The Claimant, Jackie E. Scott, signed his application for benefits on August 14, 1998, and filed it on August 17, 1998. (DX 1.) It was denied on November 12, 1998, and on February 8, 1999, the Claimant requested a hearing. (DX 16, 19.) On March 30, 1999, a Senior Claims Examiner determined that the request was not timely, and on April 27, 1999, the

[1] The following references will be used herein: "DX" designates Director's exhibits; "CX" refers to Claimant's exhibits; "EX" designates Employer's exhibits; and "Tr." designates the transcript of the hearing held on November 20, 2003.

Claimant filed a request for modification. (DX 21, 22.) That request was denied on July 8, 1999, and on July 28, 1999, the Claimant filed a request for a formal hearing. (DX 24, 26.) After another denial on January 10, 2000, the Claimant again requested a formal hearing, and on January 28, 2000, the matter was referred to the Office of Administrative Law Judges for a formal hearing. (DX 32, 34, 36.) A hearing was held before me on July 14, 2000, and on November 15, 2000, I issued a Decision and Order Denying Benefits on Modification. (DX 40, 44.) In that decision, it was determined that the Claimant had established nineteen years of coal mine employment, and while he had also established total disability, he had failed to establish the existence of pneumoconiosis or total disability due thereto.

The Claimant filed a request for modification of that denial on November 14, 2001. (DX 45.) This matter was then referred to the Office of Administrative Law Judges on October 1, 2002, and a hearing was held before me on November 20, 2003.

Factual Background

The Claimant was born on October 16, 1935, and he has a high school education. (DX 1.) He has one dependent for purposes of augmentation of benefits, namely, his wife Joyce. (DX 1, 5, Tr. 12.) The Claimant testified that his family doctor is Dr. Bradac and he sees Dr. Batra for his heart condition. (Tr. 18, 19–20.) He also continues to see Dr. Saludes. (Tr. 19.)

Coal Mine Employment

It was previously determined that the Claimant had established nineteen years of coal mine employment. (DX 44.) This finding has been stipulated to by the Employer. (Tr. 12.) There is no new evidence on this issue, and I find no error in this determination of fact. Accordingly, I find that the Claimant was a coal miner, as that term is defined by the Act and Regulations, for a period of nineteen years. He was last employed as a coal miner in the state of Ohio.[2] (DX 4.) He performed his last coal mine work in 1983. (DX 1.)

Responsible Operator

Bellaire Corporation does not contest that it was properly named the responsible operator herein. (Tr. 10.) Accordingly, I find that Bellaire Corporation is the Responsible Operator in this case.

Adjudicatory Rules

Because this claim was filed in 1998, it is governed by the regulations at 20 C.F.R. Part 718. Amendments to the Part 718 regulations, which are applicable herein, became effective on January 19, 2001.

[2] The Benefits Review Board has held that the law of the circuit in which the Claimant's last coal mine employment occurred is controlling. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989). The Claimant's last coal mine employment took place in Ohio, which falls under the Sixth Circuit's jurisdiction.

Under Part 718, the Claimant must prove by a preponderance of the evidence that: (1) he suffers from pneumoconiosis; (2) such pneumoconiosis arises out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *Gee v. W. G. Moore & Sons*, 9 BLR 1-4 (1986) (*en banc*); *Baumgartner v. Director, OWCP*, 9 BLR 1-65 (1986) (en banc). Evidence which is in equipoise is insufficient to sustain the Claimant's burden of proof. *Director, OWCP v. Greenwich Collieries, et al*., 512 U.S. 267 (1994), *aff'g sub nom*. *Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993). Failure to establish any one of these elements precludes entitlement to benefits.

Request for Modification

The Claimant is seeking modification of the prior denial of benefits. The modification provisions at Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922 are incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a), and they provide the statutory authority to modify orders and awards. An award in a black lung claim may be modified at the behest of the claimant, the employer or the district director upon demonstrating that a "change in conditions" has occurred or that there was a "mistake in a determination of fact." 20 C.F.R. § 725.310. An allegation of a mistake or a change in law, however, does not constitute proper grounds for modification. *Donadi v. Director, OWCP*, 12 BLR 1-166 (1989). Moreover, modification is available to both claimants and employers. *King v. Jericol Mining Inc*., 246 F.3d 822 (6th Cir. 2001); *Branham v. Bethenergy Mines, Inc*., 20 BLR 1-27 (1996). Modification may be sought at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310(a).

The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949–79950, 79955–79956 (2000). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not.

The Circuit Courts and Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. *Lukman v. Director, OWCP*, 11 BLR 1-71 (1988). In determining whether a change in conditions is established, the fact finder must conduct an independent assessment of the newly submitted evidence and consider it in conjunction with the previously submitted evidence to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement that were previously adjudicated against the claimant. *Kingery v. Hunt Branch Coal Co*., 19 BLR 1-6 (1994); *Napier v. Director, OWCP*, 17 BLR 1-82 (1993); *Kovac v. BCNR Mining Corp*., 14 BLR 1-156 (1990), *aff'd on recon*. 16 BLR 1-71 (1992). Where modification is sought based upon a mistake of fact, new evidence is not a prerequisite, and the adjudicator may resolve the issue based upon "wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc*., 404 U.S. 254, 256 (1971); *Kovac v. BCNR Mining Shipyards, Inc*., 16 BLR 1-71, 1-73 (1992), modifying 14 BLR 1-156 (1990).

A review of the prior decision in this matter reveals no mistake in a determination of fact. The medical evidence discussed therein, while reviewed, will not be set forth in detail herein, and the findings made in the prior decision with regard to that evidence are incorporated herein by reference.

Pneumoconiosis and Causation

The presence of pneumoconiosis, as defined at 20 C.F.R. § 718.201, is determined under the criteria at 20 C.F.R. § 718.202(a)(1)–(4). In this case, there is no autopsy or biopsy evidence. Thus, the presence of pneumoconiosis must be established by chest x-rays pursuant to 20 C.F.R. § 718.204(a)(1), one of the presumptions set forth at 20 C.F.R. § 718.204(a)(3), or reasoned medical opinions under 20 C.F.R. § 718.204(a)(4).

Under the provisions of 20 C.F.R. § 718.202(a)(1), chest x-rays that have been taken and evaluated in accordance with the requirements of § 718.102 may form the basis for a finding of the existence of pneumoconiosis if classified in Category 1, 2, 3, A, B, or C under an internationally adopted classification system. An x-ray classified as Category 0, including subcategories 0/-, 0/0 and 0/1 does not constitute evidence of pneumoconiosis. Under § 718.202(a)(1), when two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays. *Milburn Colliery Co. v. Hicks,* 138 F.3d 524, 536 (4th Cir. 1998).

The following chest x-ray readings have been submitted since the prior denial:

Ex. No.	Date of x-ray	Physician/Qualifications[3]	Impression
DX 45	7/26/01	Cohen B	no pneumo
DX 45	7/26/01	Noble B BCR	0/0
EX 1	4/22/03	Loh	no mention of pneumo
EX 1	4/22/03	Altmeyer B	no pneumo
EX 3	4/22/03	Epstein B BCR	no pneumo

[3] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service, pursuant to 42 C.F.R. § 37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii).

The x-ray reading rendered by Dr. Loh was not for the purpose of classifying pneumoconiosis. (EX 1.) Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co*., 7 BLR 1-216 (1984); *Sacolick v. Rushton Mining Co*., 6 BLR 1-930 (1984). In the instant case, I find the reading which is silent to be negative for the disease, however, I also do not find it to be particularly relevant, given that, as noted, it was not read for the purpose of classifying pneumoconiosis. Additionally, none of the x-ray readings were positive for the disease, and therefore, the newly submitted x-ray evidence cannot establish a change in conditions, a mistake in a determination of fact or the existence of pneumoconiosis. As noted, there is no autopsy or biopsy evidence of record.

Under § 718.202(a)(3), a claimant can establish that he is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305 or 718.306 are applicable. Section 718.304 does not apply because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Section 718.306 is not relevant because it is only applicable to claims of deceased miners.

Under § 718.202(a)(4), a claimant may also establish the existence of pneumoconiosis, notwithstanding negative x-rays, by submitting reason medical opinions. However, this regulation further provides that any such finding by a physician must be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories. Thus, the Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A “documented” opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co*., 10 BLR 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 BLR 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 BLR 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields,* 10 BLR 1-22.

Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 BLR 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 BLR 1-1291, 1-1294 (1984). A physician's report may be rejected if the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 BLR 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186–187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 BLR 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co*., 7 BLR 1-236, 1-239 (1984). The physician opinion evidence submitted since the prior denial of the claim is summarized below.

Dr. Melvin T. Saludes

Dr. Melvin T. Saludes performed an Occupational Lung Disease Evaluation on July 26, 2001. (DX 45.) He listed a past medical history that included obstructive lung disease, gastroesophageal reflux disease and type II diabetes mellitus. A cigarette smoking history of six cigarettes per day for six years, the Claimant having quit smoking in 1967, was recorded, as was the Claimant's employment history. Based upon his examination, which included the taking of a chest x-ray, pulmonary function and blood gas testing, Dr. Saludes diagnosed asbestos-related lung disease and minimal evidence of coal worker's pneumoconiosis. Dr. Saludes indicated that the Claimant's chest x-ray showed minimal changes consistent with coal worker's pneumoconiosis, further finding bilateral pleural thickening consistent with asbestos-related disease. He also found a severe pulmonary function impairment. It was his opinion that the Claimant had a total pulmonary impairment, "likely secondary to coal dust exposure, asbestos dust exposure and obstructive lung disease."

Dr. Robert Cohen

Dr. Robert Cohen submitted a Consulting Medical Evaluation dated September 5, 2001. (DX 45.) Dr. Cohen is board-certified in internal medicine, pulmonary disease and critical care medicine. He based his report on the history, physical exam, chest x-ray and pulmonary function test performed on July 17, 2001, as well as additional medical evidence submitted to him for review. A smoking history of two packs per week from the age of eighteen years to twenty-four years was recorded and found to be less than a two-pack-year history of tobacco smoke exposure. Nineteen years of underground coal mine employment was also recorded. Dr. Cohen found that the Claimant had a significant, heavy and prolonged coal dust exposure, which "most certainly" could account for his lung disease. Based upon his review of the evidence, Dr. Cohen opined that the Claimant had clinical and physiological evidence of coal worker's pneumoconiosis.

Dr. Cohen pointed out that when coal mine dust exposure causes obstructive lung disease, the chest x-rays are often not positive. The fact that the x-ray evidence was negative did not change his opinion regarding the existence of pneumoconiosis. Dr. Cohen found changes on the chest x-ray that were consistent with asbestosis pleural disease; however, this would be expected to cause restrictive changes on pulmonary function testing, not the obstructive changes the Claimant exhibited. Dr. Cohen found the Claimant to be totally disabled from a respiratory standpoint, finding that impairment to be the result of his nineteen years of coal dust exposure and his two pack years of exposure to tobacco smoke. While Dr. Cohen found that the resulting impairment alone was disabling, he also noted that the Claimant's asbestosis may also have contributed to his diffusion impairment. He found that the Claimant had a severe diffusion impairment on pulmonary function testing, concluding that this can be seen in chronic obstructive lung disease as well as interstitial lung disease from coal mine dust and asbestos exposure.

Dr. Cohen submitted a supplemental report on October 30, 2003, indicating that it was based on information provided from his examination of the Claimant on July 17, 2001, as well as additional records and information given him by Claimant's counsel. (CX 1.) Dr. Cohen opined

that the Claimant did suffer from coal worker's pneumoconiosis, concluding that his chronic respiratory condition was substantially related to his nineteen years of coal mine employment, with a possible contribution by his less than two pack years of cigarette smoking. Dr. Cohen based his conclusion on the Claimant's work history, his symptoms of chronic lung disease, findings consistent with chronic lung disease, and the arterial blood gas studies that showed mild hypoxemia. Dr. Cohen also found that the Claimant had had exposure to asbestos; however, it was his opinion that this would not be expected to cause any significant physiologic impairment, further noting that it would cause a restrictive impairment, and the Claimant had severe obstructive impairment. He also concluded that the Claimant's coronary artery disease did not contribute to his pulmonary impairment. With regard to the opinions of Drs. Fino and Altmeyer that the Claimant's respiratory problems were the result of asthma, Dr. Cohen stated that he found nothing in the record which would substantiate significant recurrent bronchospasm in this individual, and opined that a diagnosis of asthma was not supported by the data. Dr. Cohen reiterated that the Claimant was totally disabled due to pneumoconiosis. He stated that the Claimant's nineteen years of coal dust exposure and two pack years of exposure to tobacco smoke were significantly contributing factors to his development of severe obstructive lung disease, while his asbestos exposure caused no "significant" pulmonary impairment.

Dr. Robert B. Altmeyer

Dr. Robert Altmeyer submitted a report dated September 22, 2002, after reviewing the report of Dr. Cohen. (EX 1.) Dr. Altmeyer pointed out that the pulmonary function study interpreted by Dr. Cohen revealed a specific diffusing capacity of 104% of predicted, the specific diffusing capacity being one of the most accurate ways of excluding pulmonary emphysema. The pulmonary function study at issue, therefore, excluded pulmonary emphysema.

Dr. Altmeyer reviewed all the points made by Dr. Cohen in support of the diagnosis of coal worker's pneumoconiosis. He noted that Dr. Cohen implied that there were only two possible causes of the Claimant's pulmonary impairment—tobacco abuse and coal mine dust exposure—and that since the tobacco abuse was negligible, by default the airways obstruction had to be due to coal worker's pneumoconiosis. However, Dr. Altmeyer considered a third possibility, naturally occurring asthma, which causes severe airways obstruction with a normal diffusing capacity, as found herein. While Dr. Cohen found severe diffusion impairment on pulmonary function testing, Dr. Altmeyer disagreed with the conclusion that this type of impairment can be seen in chronic obstructive lung disease as well as the interstitial lung disease from coal mine dust and asbestos exposure. Dr. Altmeyer pointed out that when the Claimant's diffusing capacity was corrected for alveolar volume, it was above 100 percent of predicted. Asbestos exposure only causes a reduction in diffusing capacity when that exposure has actually caused interstitial fibrosis or asbestosis, and such changes were not present in this case. Coal worker's pneumoconiosis can cause a reduction in diffusing capacity but has only been described in category 3p or complicated coal worker's pneumoconiosis. Dr. Altmeyer disagreed with Dr. Cohen's opinion that where the x-ray is negative there can be a significant degree of impairment of lung function. Dr. Altmeyer reiterated his opinion that the Claimant's pulmonary function testing was indicative of naturally occurring asthma.

Dr. Altmeyer examined the Claimant on April 22, 2003. (EX 1.) Dr. Altmeyer recorded work, medical and social histories and a chest x-ray, pulmonary function and blood gas testing. He noted that the Claimant indicated continuous shortness of breath since about 1970 and a daily productive cough that started during coal mine employment. A smoking history of five to six cigarettes per day from the age of twenty years to twenty-six years was also recorded. Family history was negative for lung disease and asthma. Based upon his examination, Dr. Altmeyer found that the Claimant does not have coal worker's pneumoconiosis. He based this conclusion on the findings that (1) there were no changes radiographically to suggest pneumoconiosis; (2) simple coal worker's pneumoconiosis has not been described in the literature as causing wheezing; and (3) the pattern of the pulmonary function studies with severe obstruction associated with acute bronchoreversibility and with a supernormal diffusing capacity was absolutely classic for the diagnosis of naturally occurring asthma. Dr. Altmeyer opined that if the Claimant were aggressively treated for asthma, his lung function and symptomatology would rapidly improve.

Dr. Gregory Fino

Dr. Gregory Fino submitted a report dated October 11, 2002, after reviewing the medical evidence. (EX 2.) Dr. Fino is board-certified in internal medicine and pulmonary disease. Dr. Fino pointed out that upon his prior review of the evidence, he had found that there was insufficient evidence to justify a diagnosis of simple coal worker's pneumoconiosis in this case. He did conclude, however, that the Claimant had a disabling respiratory impairment due to asthma. Dr. Fino found the current review did not alter his opinion as previously stated.

By report dated October 28, 2003, Dr. Fino reviewed the medical evidence. (EX 2.) Dr. Fino indicated that he had previously reviewed the evidence on three prior occasions. Based upon his review of the medical evidence from 1998 to present, Dr. Fino stated his disagreement with the findings rendered by Dr. Cohen with regard to the etiology of the Claimant's obstructive abnormality. It was his opinion that the Claimant's smoking history played no role in his respiratory impairment. He also found that the Claimant's respiratory impairment was the result of asthma, which had undergone airway remodeling. He stated that his opinion remained that the Claimant was disabled but that coal mine dust inhalation did not cause, contribute to or participate in his disability.

Dr. Philip T. Diaz

By report dated October 29, 2003, Dr. Philip T. Diaz indicated that he had reviewed the medical records on the Claimant dating from 1998 to 2003. (CX 3.) Based upon his review of the evidence, Dr. Diaz opined that the diagnosis of "naturally occurring asthma" as suggested by some outside reviewers was highly unlikely. He based this opinion on the finding that to develop such a progressive, severe airflow obstruction with little evidence of reversibility, at a relatively advanced age was highly unusual for "naturally occurring" asthma. Dr. Diaz believed that the Claimant's occupational exposure to coal dust contributed substantially to his severe alterations in pulmonary function and his respiratory impairment. It was his opinion that the Claimant was totally disabled and that the Claimant's dust exposure contributed significantly to

his disability. Dr. Diaz is board-certified in internal medicine, pulmonary diseases and critical care medicine.

Dr. Mahmood Alam

Dr. Mahmood Alam reviewed the medical records and submitted a report on October 30, 2003. (CX 2.) Dr. Alam is board-certified in internal medicine, pulmonary disease and critical care medicine. Based upon his review, Dr. Alam concluded that the Claimant's disability was not the result of asthma. In this respect, he stated his disagreement with Dr. Altmeyer, noting that the Claimant's medical condition was worsening over time, although he quit mining a long time ago. Dr. Alam noted that asthma is more likely to worsen with continuing exposure to dust, as opposed to worsening after leaving a dusty environment. Coal worker's pneumoconiosis, however, is known to get worse as the patient ages, as is the case with the Claimant. Dr. Alam further pointed out that no treating physician had diagnosed asthma, and that the Claimant's pulmonary function testing did not show any significant reversibility or bronchodilator response, the latter being a key factor in the diagnosis of asthma. He further pointed out that there was no known family history of asthma, that there was no history of asthma in the Claimant's distant past, and that initial onset of asthma in adult males is not very often seen. According to Dr. Alam, the Claimant's wheezing was not associated with weather changes or severe allergies, and individuals with asthma usually do no cough up phlegm, but rather have a dry cough, which was not the case here. Dr. Alam stated that while chronic dyspnea on exertion, cough and wheezing can also be presenting symptoms for occult coronary disease and congestive heart failure; in the Claimant's case, he had had bypass surgery correcting the coronary disease and a recent stress test argued against a cardiac etiology for his symptoms. Dr. Alam concluded that the symptoms exhibited by the Claimant, therefore, were due to chronic bronchitis and coal worker's pneumoconiosis. He found the Claimant's total disability to be due to exposure to coal dust.

Treatment Records

Records from Dr. D. K. Batra, of Batra Cardiology Associates, have been submitted. (CX 4.) On March 22, 2000, June 15, 2000, July 6, 2000, September 21, 2000, March 7, 2001, July 23, 2001, September 3, 2001, September 6, 2001, and November 14, 2001, the Claimant was seen for follow-up, having a history of stable angina, diabetes mellitus, and chest pain. He was recorded as being "status post CABG" as of September 3, 2001. On April 17, 2002, Dr. Batra recorded that the Claimant was doing well with no complaints of chest pain or shortness of breath. His Assessment was aortocoronary bypass – no signs of decompensation. Additional follow-up appointments were had on September 4, 2002, December 19, 2002, May 1, 2003, and June 18, 2003. During the May, 2003 visit, the Claimant was complaining of pressure chest pain on exertion. Dr. Batra's Assessment included chest pain and aortocoronary bypass. In June of 2003, Dr. Batra listed an Assessment of (1) chest pain; (2) aortocoronary bypass; (3) echocardiogram showed an ejection fraction of 60% and mild triscuspid regurgitation; and (4) thallium stress test was negative for ischemia. A study conducted on June 4, 2003, revealed no ischemia with normal EF.

Discussion

In my decision rendered on November 15, 2000, I reviewed the medical opinions of Drs. Reddy, Lenkey, Antalis, Altmeyer and Fino. The latter two physicians opined that the Claimant did not have coal worker's pneumoconiosis. They did, however, diagnose asthma. Dr. Reddy diagnosed chronic obstructive pulmonary disease and chronic bronchitis, predominantly due to coal dust exposure. Dr. Lenkey diagnosed coal worker's pneumoconiosis, while Dr. Antalis diagnosed severe chronic obstructive pulmonary disease. In reviewing these medical reports, I found those of Drs. Fino and Altmeyer to be worthy of the greater weight.

Upon reviewing the newly submitted medical reports, in conjunction with the medical report evidence previously submitted, I find that that evidence continues to be insufficient to establish the existence of pneumoconiosis and total disability due thereto. Thus, Dr. Saludes finds minimal evidence of coal worker's pneumoconiosis, basing his diagnosis of pneumoconiosis on chest x-ray changes. The x-ray evidence, however, is negative for the disease. Dr. Saludes provides no other basis for his diagnosis, thus rendering his opinion insufficient to meet Claimant's burden of proof herein. Furthermore, I find it significant that this treating physician found that Claimant's primary diagnosis was an asbestos-related lung disease.

In his report of 2001, Dr. Cohen finds a pulmonary impairment due to coal mine dust inhalation and cigarette smoking, further noting that the Claimant's asbestos exposure may have contributed to his diffusion impairment. He stated, however, that the asbestos-related changes found on the Claimant's chest x-ray would produce restrictive lung disease, not obstructive lung disease as found in the Claimant. In his report of 2003, Dr. Cohen found that the Claimant's pulmonary impairment was due to coal mine dust inhalation with a possible contribution by his smoking history. He concluded that the Claimant's nineteen years of coal dust exposure and two pack year history of exposure to tobacco were the significant factors in his severe obstructive lung disease, while his asbestos exposure did not cause a significant pulmonary impairment. Dr. Cohen fails, however, to explain how he finds that the minimal exposure this man had to tobacco played any role in his pulmonary disease. Similarly, while providing conflicting opinions on the role exposure to asbestos played in the Claimant's pulmonary condition, he fails to adequately address how he can distinguish between the role played by coal mine dust inhalation as opposed to asbestos exposure, given that he finds that both can cause the severe diffusion impairment he finds in the Claimant. Thus, when finding severe diffusion impairment, he states that this can be due to coal mine dust exposure and asbestos exposure; however, he fails to indicate whether it is possible to determine the etiology when an individual has had exposure to both. He then finds the Claimant's disability to be due to two factors, one of which was minimal when compared to the asbestos exposure. I find his medical opinion to be conflicting, and for this reason, insufficient to meet the Claimant's burden of proof.

Dr. Diaz, who reviewed the medical records, opined that the Claimant's dust exposure was the significant contributor to his pulmonary disability. He stated that it was highly unusual to develop "naturally occurring" asthma at a relatively advanced age, as he noted some outside reviewers had suggested. However, it is noted that while Drs. Fino and Altmeyer diagnosed asthma, they do not appear to provide its onset date. I find the opinion of Dr. Diaz to also be deficient as he fails to provide a basis for the conclusion that the Claimant's disability is related

to coal mine dust exposure, in light of the other possible etiology: asbestos exposure. In this respect, Dr. Diaz makes no mention of the asbestos exposure or how he could differentiate between any potential impairment caused thereby versus that caused by coal mine dust inhalation.

Dr. Alam also finds that the Claimant's disability was not due to asthma, pointing out that no treating physician had diagnosed asthma, and concluding that the Claimant's symptoms were due to chronic bronchitis and coal worker's pneumoconiosis. Dr. Alam relies upon the fact that the Claimant had had bypass surgery to rule out a cardiac etiology for his symptoms. However, in treatment records dating from February of 2000, Dr. Lenkey recorded that the Claimant had a ten-pack-year history of cigarette smoking and that he had been told that he had asthma. (DX 39.) Therefore, it cannot be said that the treatment records make no mention of asthma, and given that the treatment records which have been submitted in this case date from the recent past, the record is silent as to what was diagnosed when the Claimant was of a younger age. Furthermore, there is no evidence of record that the Claimant has had bypass surgery, and in his testimony at the hearing, he specifically denied that he had. (Tr. 18.) It does not appear, therefore, that Dr. Alam had an accurate understanding of the Claimant's status at the time he rendered his opinion.

In their recent reports, Drs. Fino and Altmeyer continued to find that the Claimant did not suffer from pneumoconiosis. In his report of June 18, 2000, Dr. Fino had found that the Claimant's diffusing capacity values were normal, which ruled out the presence of clinically significant pulmonary fibrosis. (DX 38.) In his recent reports, Dr. Fino continued to find that the Claimant was disabled due to asthma. Dr. Altmeyer also found that the Claimant suffered from asthma, noting that the Claimant had a supernormal diffusing capacity and severe obstruction on pulmonary function testing, which the physician noted is classic for the diagnosis of naturally occurring asthma.

Upon reviewing the medical opinion evidence, I do not find it sufficient to meet the Claimant's burden of proof. In so concluding and for the reasons set forth above, I do not find the medical opinions of Drs. Saludes, Alam, Diaz or Cohen sufficiently well-reasoned and well-documented to affirmatively establish that the impairment suffered by the Claimant is coal worker's pneumoconiosis, even when coupled with the medical opinion previously submitted in this matter and considered by me in my prior decision. In this respect, I continue to find that the medical opinions of Drs. Altmeyer and Fino establish otherwise. The newly submitted treatment records are also insufficient to establish the existence of the disease. In sum, I do not find the medical opinion evidence sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4).

Total Disability

While the Claimant has been found to be disabled, the newly submitted medical evidence on this issue will be briefly discussed.

Pulmonary function studies can establish total disability where the values are equal to or less than those listed in Table B1 in Appendix B to Part 718. The newly submitted pulmonary function testing is as follows:

Exhibit No.	Date	Physician	Age/Height	FEV1	FVC	MVV
DX 45	7/26/01	Saludes	65/63"[4]	.83	2.00	29
EX 1	4/22/03	Altmeyer	67/62"	.82	2.18	34
		Post-bronchodilator		.99	2.36	47

Both of the newly submitted studies produced qualifying values pursuant to 20 C.F.R. § 718.204(b)(2)(i).

Under the provisions of subsection 718.204(b)(2)(ii), a claimant can establish total disability if arterial blood gas tests show values conforming to Appendix C to Part 718. The following blood gas studies have been submitted since the prior denial:

Ex. No.	Date	Physician	PC02	PO2
DX 45	7/26/01	Saludes	42.1	79.9
EX 1	4/22/03	Altmeyer	43.5	65.6

Neither study produced values indicative of total disability.

Section 718.204(b)(2)(iii) is not applicable here, given that there is no evidence of cor pulmonale with right-sided congestive heart failure. Section 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. It is uncontested that the Claimant is totally disabled by a respiratory impairment in this case.

However, in order to be entitled to benefits, the Claimant must establish that his total disability is due to pneumoconiosis. Total disability due to pneumoconiosis requires that pneumoconiosis as defined in 20 C.F.R. § 718.201, be a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Substantially contributing cause is defined as having a "material adverse effect on the miner's respiratory or pulmonary condition" or as "materially worsen[ing] a totally disabling respiratory or pulmonary impairment which is

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). In my prior decision, I ruled that the Claimant was 63.25", however, given the newly submitted studies, I find that his height is 62.5". In so doing, I have taken the average height of the two most recent studies. Both of the tests are qualifying to show disability, whether considering the average height or the heights listed by the physicians who administered the testing.

caused by a disease or exposure unrelated to coal mine employment." 20 C.F.R § 718.204(c)(1)(i) and (ii). Absent a showing of cor pulmonale or that one of the presumptions of § 718.305 is satisfied, it is not enough that a miner suffer from a disabling pulmonary or respiratory condition to establish that this condition was due to pneumoconiosis. *See* 20 C.F.R. § 718.204(c)(2). Total disability due to pneumoconiosis must be demonstrated by documented and reasoned medical reports. *Id*.

In the instant case, I have found that the Claimant has failed to establish the existence of coal worker's pneumoconiosis. It follows, therefore, that any disability suffered by him cannot be the result of that disease. Accordingly, I find that the medical evidence of record fails to establish total disability due to pneumoconiosis as required by 20 C.F.R. § 718.204(c)(1).

Entitlement

Since Claimant has failed to establish the existence of pneumoconiosis arising out of coal mine employment or total disability due thereto, he is not entitled to benefits under the Act. His request for modification must therefore be denied.

Attorney Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Jackie E. Scott is hereby DENIED.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.